International Seminar on People's Participation in Health
Dhaka, Bangladesh 28 February 2007-03-01

Remarks to the Opening Session

[jokes can be edited out if wished]

It is a privilege and pleasure to be invited to this seminar. It is an exciting time to be alive as a development professional, when so much is happening and change is accelerating, not least in the invention, evolution and spread of participatory methodologies. It is also an inspiring time to be in Bangladesh when so much is transforming and so many possibilities have opened up with so many hopes for the future.

I am also daunted and embarrassed. There are hazards in ageing, and I have been learning to notice thresholds or milestones as it progresses. One is the first time you hear yourself described as "sprightly"; another the first time a young woman gives up her seat to you; then there is the first time you are in a queue and offered a wheelchair; and again, being introduced, which has mercifully not happened this time, with the terminal words "He has spent his lifetime.." . A greater hazard, though, is being asked to "deliver a keynote address" on a subject on which you are more ignorant than you care to admit. You may be out of touch and out of date. But it is flattering, and tempting when it would mean visiting a country like Bangladesh. So I did not put up much of a fight and am so delighted to be here.

Another hazard is a high ERR. This is not the Economic Rate of Return, but the Egocentric Reminiscence Ratio, the proportion of a person's speech devoted to personal recollection – "I remember....When I was..." There are five hypotheses about the ERR: that it is higher among men than women, rises with age, on retirement leaps to new plateau, is higher in the evening than the morning, and rises sharply with the consumption of certain liquids. I assure you that I am totally sober, and we know it is the morning. But being defenceless on the other three counts, I hope you will understand and forgive my sharing two recollections.

The first is that I have often been wrong in the past when sure that I was right. I will spare you details. But if past performance is anything to go by, I am likely to be wrong in some of the things I say today. Please bear this in mind, and be critical and use your own judgement based on your own experience.

The second is a story of white water canoeing. This is not an activity for which Bangladesh has a physical comparative advantage. Have any of you done it? [Only two hands went up] . But you have seen it on television. The canoe is unstable. All you have is a paddle. The second (and last) time I did it we came to unexpected rapids, with white water pouring wildly over big rocks, and swirling in between them. I thought that this was it! I could not imagine surviving. This is not a moment when you look up what to do in the manual. You just have to live it as best you can. And with concentration and with a lot of luck amazingly I got through. As I came out into the calm water I almost shouted out "I've done it!". And that was when I tipped over.

In human affairs, are we in white water? And does this mean that the moment we think we have the answer to anything, we have lost the plot, and will tip over? That we have continuously to learn (and unlearn)? And is this indeed as exciting and enthralling as white water canoeing itself?

A keynote can be flat, natural or sharp. Let me try to pass on the flat, apart from what I have already said, and proceed with three observations which I believe may be natural, in the sense of true but inadequately recognised. And then conclude with five challenges to all of us, which I hope are relevant and sharp.

Three Habitual Underestimates

Do we and development professionals generally tend to underestimate the importance of three things: the value of the body to poor people; the capacity of people to do things for themselves; and the significance of power and relationships?.

1. ***the body as asset and health as a priority***

For most poor people, the body is their most vital asset. To survive they have to work. For that, they need health and strength. If one of us has an accident we may still be able to work, with our minds. For the vast majority of poor people, this is not an option. Their bodies matter more to them than they do to us. The poor people who analysed their conditions and priorities in the Voices of the Poor study in 23 countries so stressed the importance to them of being well, fit, strong and with good access to health services, that a whole chapter of the synthesis of the study came to be entitled "The Body" (Narayan et al 2000: 89-108). The women of SEWA (the Self-Employed Women's Association) in India have a poster with the slogan "OUR BODIES ARE OUR WEALTH". Their livelihoods, their families, their survival depend on the conditions and strength of their bodies. Their bodies are overwhelmingly their main, sometimes almost their only, asset, and a precondition for being able to exercise their skills.

But compare a poor person's body with other assets. Unlike many other assets the bodies of poor people are:

- Indivisible (compared say with money, or a few goats)
- Vulnerable (to accidents, sickness, under or malnutrition, many dangers and risks in life and work)
- Uninsured (with few exceptions)
- In need of daily maintenance
- Liable to flip from asset to liability (The twist is cruel, for a sick or injured person not only cannot work or earn, but must be fed, cared for, and if possible treatment sought and paid for)

The labouring body (as Parasuraman and others (c2004) have movingly observed is often inscribed with suffering and deprivation.

All this means that health and treatment for sickness matter more for those who are poorer than for those who are better off. Indeed, there has been repeated evidence from Participatory Poverty Assessments that health is the highest priority for many poor people, above education. Moreover, sickness and its costs are devastatingly common as a cause of poverty, making poor people poorer. Using the new Stages of Progress methodology which he has evolved, Anirudh Krishna (2006 and earlier) and his colleagues have found in a five country study that sickness is the highest cause of descent into poverty, being a factor in between 60 and 88 percent of cases. Most strikingly, in Gujarat, it was the most common cause in all of 27 villages except one where an NGO was providing a good health service. There, only 1 out of 8 cases of descent into poverty was attributed to sickness or accident **check figures and sources.** And many of us will be familiar with how often widows are left impoverished or destitute after family assets have been sold off to pay for their sick husband's treatment until his death.

Do we all then, and perhaps especially many officials in Ministries of Finance and economists, underestimate the importance of the body? And, quite apart from the human dimension of mitigating suffering, do we tend to underestimate the value, the cost-effectiveness, of providing good health services which enable poor people to avoid becoming poorer compared with, once they are poorer, enabling them to claw their way back up again, which they may never be able to do?

2 *"They can do it"*

This PRA slogan can be applied to all upper-lower relationships. Do "uppers" (adults, parents, doctors, teachers…) habitually underestimate the ability of "lowers" (children, patients, students…) to do things? We know now that children are capable of seeing another person's point of view far younger than was supposed by the great Swiss psychologist Piaget. We know – it is only commonsense – that patients are the experts, not the doctors, on how they feel and the history of their sickness. We know that students, facilitated instead of instructed, can blossom in their ability to learn for themselves. And so it goes on, and in our context can apply to communities' capacities. But for people to find out for themselves and show what they can do, the relationship with the outsider is critical. As the rubric for this seminar says "Outsiders can help, insiders must do the job". Community Led Total Sanitation (Kar and Pasteur 2005; Kar and Bongartz 2006), is a remarkable innovation evolved in Bangladesh, and now quite widespread in parts of India, Cambodia and Indonesia, and about to be introduced by Plan International into at least 6 African countries. In CLTS, the outsider facilitates appraisal and analysis; but action depends on the people. And the people of many rural communities have discovered and shown that "They Can Do It".

3. Attitudes, Behaviour, Power and Relationships

The neglect of attitudes, behaviour, power and relationships has been endemic in development policy and practice. There are exceptions. But normally "training" and "capacity building" concern teaching or imparting "skills" rather than changes in behaviour and attitudes. And power is a word little used until recently, and yet fundamental to relationships and what happens in development. But now these are more and more named and recognised and confronted (See for example Kumar 1996; Eyben ed 2006; Eyben, Harris and Pettit 2006). Many of the defects of top-down development, and gains from bottom-up development, are related to behaviour, attitudes and power. Given how fundamental these are to participation and its facilitation, it is astonishing – dare one even say pathological – how rarely these have been recognised, named and confronted.

So in sum, for our concerns here in this seminar, there is the question, whether these three aspects or dimensions, when recognised and acted on, can open up potentials for participation that will enhance the wellbeing of those who are poor, vulnerable and marginalised.

Five Challenges

This brings us now to the five challenges. Not all of these should necessarily be confronted in our discussions. But let me name them for consideration.

1. *Causes upstream.* The imagery is well know of the person who sees babies floating down in a river, and keeps on fishing them out, again and again, without thinking to go upstream to find and stop whoever is throwing them in. Does this to some degree apply with curative services and actions? I do not underestimate the importance of the curative side. The huge contribution of ORT is an example. But there is a sense in which ORT alone is fishing out the babies – totally right and justified, but not stopping them being thrown in. So can the clear benefits of curative actions mean that upstream potentials are relatively neglected? This is not a new question. Sanitation is the most obvious case. When I saw the title for this seminar, and knowing the work that Plan has been doing in Bangladesh with CLTS, I thought that would be a main focus. The benefits from total as opposed to partial, sanitation, though yet to be quantified through research (which I understand ICDDR,B is proposing to conduct), are inherently plausible, most obviously from reduced faecal-oral infections, and for children and women, and also for men. The effects on human wellbeing, and on the other MDGs, of a rural Bangladesh that was ODF (open-defaecation free) simply blow the mind. So should we remember this aspect, even if we do not discuss it much here?

2. *Whose reality?* Whose reality counts? "Ours"? Or "Theirs"? And can our view of our importance lead us into error? Let me ask Penina Achola, the Plan Regional Coordinator for HIV/AIDS in Eastern and Southern Africa, to tell us an apposite story:

> A rooster crowed every night before dawn. And then, after it had crowed, every time, the sun came up. So the rooster believed that his crowing made this happen: He caused the sun to rise. Then one night, he had a bad sore throat and could not crow. All night he agonised with terrible anxiety. He would be unable to make the sun rise. This was the end. But, of course, the sun did rise, just the same as ever.

Are we sometimes like the rooster? Do we believe that we are indispensable? That without us "nothing will happen"? And can this lead us to underestimate what people can do for themselves? Do we with a belief in our own knwoledge project "our" reality onto "theirs", and miss much that matters? Seasonality is a case. We are season-proofed, with shelter, fans, even air conditioning. We do not travel at the most difficult times of year for poor people – in the monsoon. I am ashamed at my own

behaviour. I am a *sheeta pakhi* **(spelling?)** one of those winter bird migrants from Europe who come at our worst time of year, and your best, in January, February and March. And here I am again, at that same time, and once again missing the most difficult time for poor people. .

So are our mindsets, habits of thought, and institutions, part of the problem? CLTS is a remarkable example of this. For CLTS to work, we have to turn on their heads no less than four of our outsider tendencies and reflexes:

- Professional: toilets must be well designed, by us. Things – toilets, matter more than people and processes
- Bureaucratic: we must work to targets, and disburse funds
- Donor: money is needed, and we must give more if more is to be achieved
- Philanthropic: we have to help the poorest, so we must provide hardware subsidies

The extraordinary reality is that CLTS is only achievable when all four of these are turned on their heads (Kar and Pasteur 2005; Kar and Bongartz 2006). It needs good facilitators, good facilitation, and follow up support and encouragement, and communities do the rest. But reversing these normal reflexes is proving difficult, and this is denying poor women and children, and also men, what appear to be huge gains in wellbeing.

Health and medically trained staff may suffer a special disability, compared, say with agricultural scientists. For the latter the specialised knowledge of farmers is so patently clear that it is relatively easy for them to recognise that they must learn from farmers. But health and medically trained staff to a greater degree do have specialised and powerful knowledge, and know that they have this, making it harder for them to listen and learn.

3. ***The Poorest.*** Everywhere reaching and serving those who are poorest, most marginalised and weakest presents a formidable challenge. In the Voices of the Poor study in Bangladesh (un Rabi et al 1999: 21-26), people themselves identified five categories of people according to degrees of wealth and wellbeing: the rich, the middle, the social poor, the helpless poor, and the bottom poor (*khub kashte chole)* also described as the hated poor. The helpless poor "are identifiable from their poor clothing and wretched faces. They live without health care and education, cost of both is beyond their ability. They cannot offer dowry and cannot entertain guests" (25). Neither they nor the bottom poor had access to microcredit (this was in 1999), and were often in debt to moneylenders. Of the bottom poor it was said "Prevalence of illness among family members is high, which is a consequence of low food intake, lack of access to sanitation and inability to bear the cost of treatment."(26). More recently, there has been a finding that only 17 per cent of treatment-seeking visits by members of very poor households have been to government facilities (SDS cited in HNPPP 2005). And when they do go, the poor actually have to pay more than others in unofficial fees and for drugs at public facilities (Azam Al: 2).. The BRAC paper abstract (Kausar Afsana) says that for the extreme poor "there are examples where the village committees secured funds to cover partial costs of treatment". Plan's MCH **bbbb** has a support plan for the poorest. But the coverage of such actions is likely to be very limited, leaving major challenges and questions, including how to encourage and facilitate a community ethos (one wonders for example through the spirit and practices of zakat) to enable the poorest to have equitable access to health services.

4. ***Attitudes and behaviour.*** In many countries, the attitudes and behaviour of health staff are a problem, and deter poor people from seeking health services. Bad staff attitudes, likely to affect the poor particularly are mentioned as a disincentive to using public services (HNPPP 2005). Poor people are treated rudely, without respect, receive inferior treatment, and are kept waiting while those who are better dressed go ahead of them. Yet the opportunity cost of time in terms of wellbeing is higher for most poor people than for those who are better off. It is the middle classes who should then be kept waiting. A Reflect Group in Bangladesh told me a year ago that anyone with a mobile phone would receive preferential treatment. It is suggestive that an exit client interview survey for Community Clinics piloted by Plan Bangladesh (which might reasonably be expected to be above average) , while 99 per cent said the quality of service was satisfactory (48 per cent said good), only 27 per cent reported that the provider behaved well.(ESCCS nd: 2). In another study in Comilla (Azam Al 2007) is remarkable in finding that 77 per cent of those interviewed said that the health staff were friendly. This may show what can be achieved, but the conditions were probably quite exceptional through the involvement of the Comilla Medical College. More generally, there are many stories of absenteeism and of callousness. The remarkable achievements of Malaysia in reducing maternal mortality resulted from "the strong commitment of health care providers and policy makers" (Koshy and Bahrin 2007). One has to ask where this commitment came from, and how it can be engendered and supported. For the present, in Bangladesh, are bad attitudes among staff an Achilles heel of health care?

5. ***Going to scale.*** Thinking about going to scale, we can distinguish two broad types of situation. The first are those which are physical - where a standard and predictable environment -- like the human body, can receive and benefit from a standard intervention – immunisation and ORT being examples. Immunisation in particular is amenable to top down time bound, targeted and widespread standardised programmes. The second type is social situations, where the environment is variable and unpredictable, and standard top down , targeted and time bound programmes simply do not work. Often patience, commitment, flexibility and above all time are needed

   Donors and lenders are a problem here. As they increasingly seek to harmonise their programmes, reduce their staff, and put their money in common pots, it becomes ever harder for them to provide assistance on a small scale. Sustained support over a long period may also be becoming harder. I have heard informally that in Bangladesh, nothing less than $50million can be reasonably considered, meaning that a "modest" request for $1 million was out of the question. Pressure comes then from donors for large programmes and rapid disbursements, precisely what is not needed for scaling up social and organisational pilots and innovations. In consequence, the prospect is of a sequence of lender and donor financed programmes which will fail, from which we will only learn old lessons, and which may

even do more harm than good. With CLTS, the staff of the Water and Sanitation Programme of the World Bank have been exceptional in understanding this and acting appropriately. But sadly, this is an exception. A large grant to an NGO can be disabling, unless that NGO is already adequately staffed and able to handle it. Lenders and donors are then, increasingly, part of the problem. And Governments too tend to introduce changes top down all over a country all at once, without pilot testing, and gradually spread. The challenge is to restrain both lenders, donors and Governments from rushing and going to scale too fast.

Democratic decentralisation has been advocated as a means of overcoming some of these problems. The bad news is that so far it does not appear to improve service delivery. The January 2007 issue of the Institute of Development Studies (IDS) Bulletin is a review of experiences round the world. The editor concludes his summary and overview with these words:

Quote to be inserted as marked in the Bulletin (Robinson 2007: **bb**)

Democratic decentralisation as a solution on its own should, it would seem, be regarded with scepticism. And this must raise questions whether Local Level Planning is different from other experience, or likely to suffer from similar defects.

Another challenge is to combine NGO and Government initiatives, starting small, learning lessons, avoiding very special treatments that are not replicable, and seeking to optimise with the best of both worlds – the innovative flexibility of NGOs, and the scale and coverage of Government. The challenge too is not to look for just one approach, but to encourage and learn from a creative diversity, with varied forms of spread – through movements, through integration in government systems, through lateral spread, and through increasing the size of organisations, where Bangladesh has led the world with large organisations with health programmes like BRAC and GK. The question has to be asked whether in the longer term much of the future should lie more with the government and improving the government services.

2 March 07 Robert Chambers

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Remarks at the Concluding Session on 1 March 07

Apologia. I have augmented and modified these notes following reflection, and comments from others

This session has been called The Way Forward. At the final stages of a seminar or workshop like this, we do need to be positive and to look forward to practical action. At the same time, it is not for me to say what should be done, certainly not in any detail. Selina's comprehensive yet succinct summary has given us an excellent overview of the main significant points that have come up and been made.. We agreed that I would pick out a few, and also touch on other aspects and raise other questions which might deserve attention. So I shall review and reflect on some of the rich harvest of experiences and insights with which we have been presented, and relate these to wider principles and ideas.

(Part of this is to reinforce what has not been covered, and part to point to what we have not considered, or not considered much. It is much to the credit of presenters that unlike me they have been disciplined and stuck to their allocation of 15 minutes. During such brief periods it has been masterly how much they have been able to cover. There have been many leads and insights, and the benefits should emerge as we return to our work. The devil, as ever, is in the detail, and much of this can be consulted in the full papers. It is inherent in writing a paper and presenting a power point, that there are issues that have to be covered and issues than cannot be covered, or which deserve more attention. And others arise during discussion.) **cut this para?**

Yesterday's challenges. On the five challenges I posed yesterday, we have not considered community participation in the upstream issue of sanitation, as with Community-Led Total Sanitation. That remains a hot topic of great importance because of its potential. Issues of whose reality?, and changing "our" attitudes and behaviour, have remained largely implicit rather than explicit. How the poorest can be reached, supported and included has been mentioned more often. And questions of how to take pilots and small and local successes to scale has been a recurrent theme.

Power and relationships. In development discourse generally, one of the more striking developments of the past few years has been the new prominence given to discussion of power and relationships (e.g. Eyben 2006; Eyben et al 2006). They are of pervasive significance. Like the elephant in the room, they are everywhere, and consequently easy to overlook. And they were there implicitly in our discussions. Let me illustrate this. This morning I kept a record of the number of times certain words were used. Of these the two top scorers were Participation (47) – hardly surprising as it is the theme of the seminar, and Empowerment (16) –often community empowerment or women's empowerment. Taken together, these two top scorers represent the main thrust and intention of much of the experience presented. And both of them refer to changes in power relations, as does much that follows. Moreover, today's discussion, more than yesterdays, has raised questions of power with more mention of rights (12), accountability (9) and voice (8). It is worth noting here that changes in power relations, in which those (uppers) with power over empower lowers are not a zero sum game, but often win-win for all (Chambers 2006). And changes in power relations and relationships are fundamental to improving service delivery.

Types of action. The seven areas of action which follow, lend themselves variously to

- search for and sharing experiences and ideas
- research to find out what is happening,
- innovation, piloting and spreading

Each of these seven has question marks – how important is it? How much difference could it make? How practicable could it be? Should it be explored and acted on? And where, how, and by whom? All imply and require changes of mindset and power relations.

- *Accountability and transparency.* Find out more about experience to date with report cards. Pilot, monitor and evaluate the use of report cards combined with publication in the press (as with the original report cards in Bangalore). Initiate transparent and participatory budget processes at the local level. Display budgets and monitoring information publicly, as in the Philippines (seminar presentation). Draw lessons from the monitoring carried out by the People's Health Movement and see if it can spread. Find out about other experience with local empowerment with health services (e.g. in Uganda and Malawi) and with downward accountability elsewhere.

- *Realism about the local level.* Research and recognise the realities of Local Level Planning, the scale and impacts of health service providers behaviour, especially unofficial charges and absenteeism, and explore and pilot reforms including through downward accountability and transparency

- *The realities of health service providers.* Research to understand reasons for commitment or indifference, caring or callousness, and the realities and motivation of doctors, nurses and others, with the aim of being able to see things from their point of view, understanding why they behave as they do, enquiring about what would make a difference, and then evolving realistic policies, not beating heads against brick walls.

- *Attitudes and behaviour.* Pilot training in attitudes and behaviour, including role plays, theatre, participatory video, peer monitoring and feedback, participatory field research, critical reflection….. – for all types of health professionals, including doctors in their courses.

- *Services for the poorest and* weakest. Participatory research a. with and by very poor people, and with and by women and children, to identify their priorities and what realistically would make a difference to their access and wellbeing, and b. with and by better off members of communities, facilitating their analysis of the situation

- ***Participatory numbers, and PPAs.*** Evolve and introduce participatory statistics (Barahona and Levy 2003), as in the Philippines (Nierras 2002) to enhance realism and reverse power relations. Conduct PPAs around health issues in ways which generate aggregate statistics, as in the pioneering UNDP PPA in Bangladesh in 1996

- ***Going to scale.***[1] Avoid overgeneralising about going to scale. Review the lessons of experience and treat each case separately on its own merits. Recognise the common needs forlong-term commitment, patience and minimising unreplicable special treatments. Create enabling environments. Restrain lenders, donors and government from pushing too much money too fast, and encourage them to sustain support over the long term as long as learning and change are taking place. For lenders and donors, institute a programme of counselling and therapy to enable them to resist the pressures to go to scale too fast, or to abandon pilots during their difficult early years. Learn from the WSP of the World Bank which managed to support the spread of CLTS, contrary to Bank practice, spending very little – how did they do it?

And throughout, learn, unlearn, commit, hang in there, and enjoy!

2 March 07 Robert Chambers

Postscript: Word counts from the presentations and discussions, the two morning sessions on 1 March.

Participation	47	(hardly surprising as it is in the theme of the seminar)
Empowerment	16	(often community empowerment, or women's empowerment)
Rights	12	(especially People's Health Movement)
Accountability	9	(less mentioned on day 1, except by Shehlina)
Partnership	8	
Voice	8	(especially People's Health Movement)
Transparency	3	(not mentioned on day 1)
Absenteeism	2	
Attitudes and behaviour	1	
Power	1	
Solidarity	1	
Ownership	-	(a strange anomaly, as it was much used yesterday)
Motivation	-	
Seasons	-	

Commitment, and advocacy, were used but I was not counting them.

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[1] I have wrestled unsuccessfully with this obtuse subject and failed to find a practical theory, see Ideas for Development chapter 4, and also references in that book. What usually emerge are quite long check lists of aspects to examine, and the conclusion as here that each case needs to be examined on its merits.